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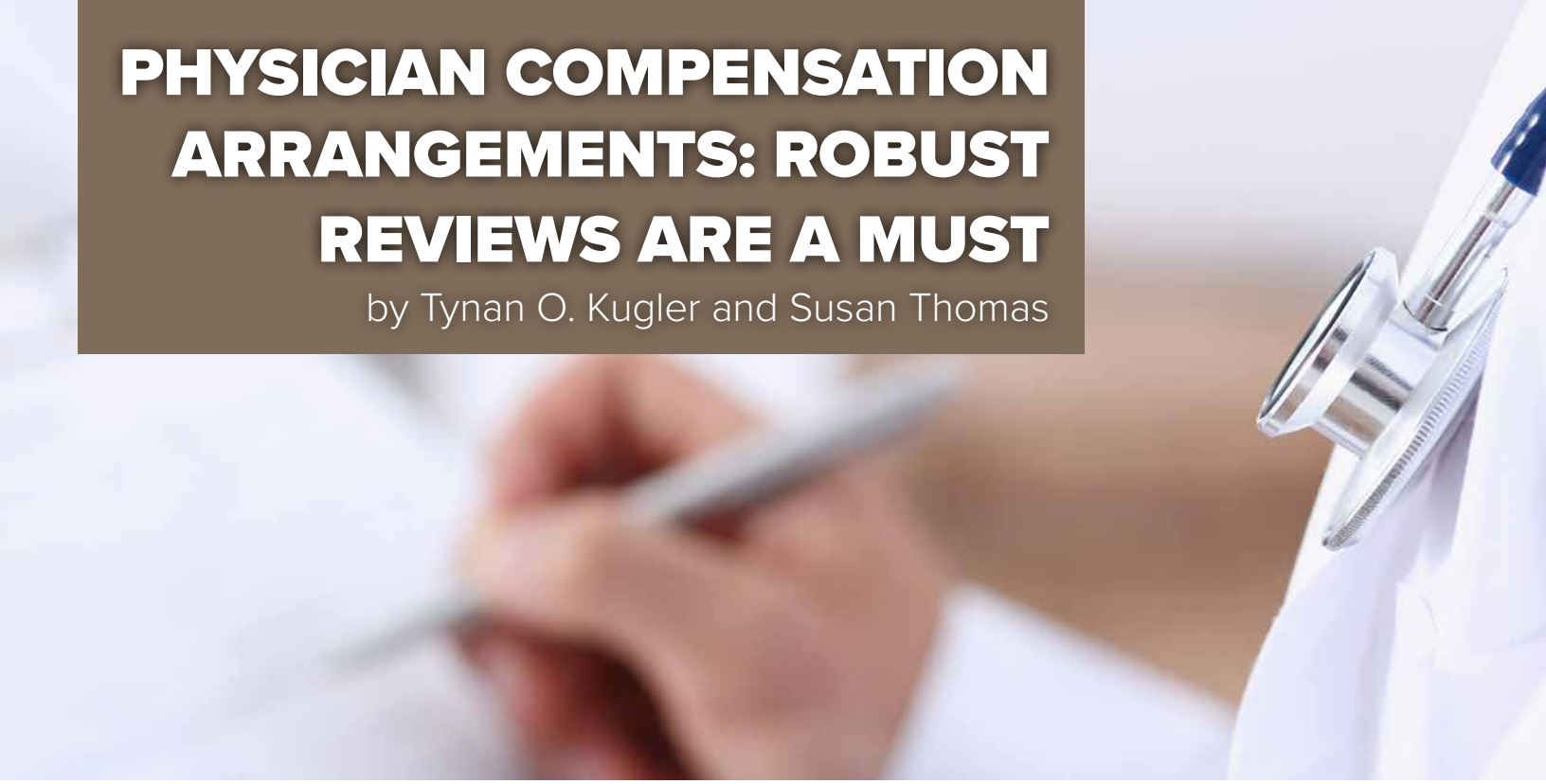
PHYSICIAN COMPENSATION ARRANGEMENTS: ROBUST REVIEWS ARE A MUST

by Tynan O. Kugler and Susan Thomas



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Negotiating physician compensation arrangements has become more prevalent as an increasing number of physicians are employed by, or contract with, health systems, hospitals, and healthcare facilities to provide various services. Such arrangements are often complex, with multifaceted compensation, production, and quality-related elements, making them subject to hard-hitting regulatory scrutiny. Therefore, it is vital that hospital and health system executives implement robust contract management systems to assure the arrangements are negotiated in compliance with regulatory guidelines. Further, all involved parties should ensure that the supporting documentation adequately substantiates contract provisions for the defined arrangement.

The burden to make certain that physician arrangements are compliant with regulatory and legal considerations can be overwhelming. Violations of the Stark Law (Stark), Anti-Kickback Statute (AKS), or the False Claims Act (FCA) can not only be costly, but also embarrassing to a health system, its physicians, and its executives—potentially causing long-lasting reputational damage and distrust. In recent years, several hospitals have paid massive penalties, ranging from $25 million to $115 million, for excessive or improper physician compensation arrangements that exceeded fair market value (FMV) and may not have been commercially reasonable.[1]

For this reason, health system executives must recognize the need for conducting a thorough review of physician arrangements on a regular basis. Organizations will be in a stronger position if physician compensation arrangements are a fundamental component of their compliance work plans. Many potential compliance violations can be mitigated—or even prevented—by completing regular, detailed compensation arrangement reviews.

Physician compensation arrangement tracking may not be a top priority for some organizations, given limited resources and competing concerns. This is complicated by the fact that an organization's management of such arrangements may be decentralized or, in larger systems, perhaps maintained by external parties including legal

counsel. However, comprehensive contract review and management is essential to ensure that the arrangements are current and meet organizational and regulatory requirements. Analyses of physician arrangements can reveal complicated party relationships, which could bring legal challenges. Furthermore, the executed contracts may often contain unintentionally vague language.

These issues can lead to uncertainty and a misunderstanding of the arrangement, inadvertently creating situations that otherwise could have been mitigated if thoroughly and proactively addressed. Physician compensation arrangements are often multifaceted—covering multiple services in a single arrangement, which can significantly impact FMV and commercial reasonableness. Commercial reasonableness is defined by the Stark Law as:

> An arrangement will be considered 'commercially reasonable' in the absence of referrals if the arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician (or family member or group practice) of similar scope and specialty, even if there were no potential DHS [designated health services] referrals.[2]

Increased scrutiny

As the aggregate number of physician compensation agreements increases so, too, does regulatory oversight. Federal statutes, such as Stark, AKS, and FCA, directly affect physician employment or contracts for services, as do some state laws. Steep penalties can be imposed for noncompliance, particularly related to financial relationships with physicians.

Stark prohibits referrals for healthcare services amongst physicians and the entities with which they have financial relationships, unless the arrangement is structured to fit within a regulatory exception. Sanctions include repayment, fines, and exclusion from federal healthcare programs.

AKS prohibits the exchange of, or offer to exchange, anything of value that may influence the referral of federal healthcare program business. Criminal and civil penalties can be levied against any individual or entity that knowingly and willingly offers, pays, solicits, or receives any remuneration—including any kickback, bribe, or rebate—directly or indirectly, overtly or covertly, in cash or in kind, to any person to induce referrals, or to purchase, order, or lease an item.

FCA places liabilities on companies and individuals who attempt to defraud federal programs. It prohibits any person from knowingly presenting, or causing the presentation of, a fraudulent claim for payment to a federal healthcare program. The FCA has become an important, if not *the* most important, governmental tool for demanding healthcare providers' compliance with the requirements of federal healthcare program participation. Under the FCA, hospital or physician service payments that violate Stark or AKS are considered fraudulent. The FCA creates liability for any individual who knowingly uses or submits (or causes to be submitted) a false record, statement, or claim for payment to the government. Proof of intent to defraud is not required.

Steep penalties may also result from lack of compliance with various other certifications as the content identified within physician arrangements is central to completion of other critical governmental documentation. For example, certification requirements for Medicare cost reports must be taken into consideration. The misrepresentation or falsification of any information in a cost report may be punishable by criminal, civil, and administrative action, as well as a fine or imprisonment.

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Specifically, the Medicare cost report includes facility costs associated with physician administrative time (Part A) and physician patient treatment time (Part B). The Centers for Medicare & Medicaid Services (CMS) expects that physician compensation agreements entered into by hospitals and health systems appropriately allocate the compensation between the administrative and professional components. Specifically, all physician time is defaulted to

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Part B, unless documentation shows the time qualifies for Part A. To report allocation of physician compensation, all compensation must be identified and quantified. Next, documentation must be reviewed to segregate Part A from Part B. Part A is reimbursable on the cost report and must be documented and verified with time studies, timely attestation signatures, and implementation of contracts.

Compliance with filings and the aforementioned laws has increasingly taken center stage as oversight agencies, such as the Department of Health and Human Services Office of Inspector General (OIG), have reinforced their goal to reduce healthcare fraud, waste, and abuse. Several dedicated entities have stepped up efforts to combat healthcare fraud, including the Medicare Fraud Strike Force, the FBI Healthcare Fraud Prevention Partnership, the IRS Healthcare Fraud Criminal Investigation Unit, the OIG Health Care Fraud Prevention and Enforcement Action Team, and the USPS Office of Investigations Healthcare Provider Fraud Unit.

Such agencies are increasingly pursuing allegations against individual physicians and other providers, not only the hospitals and other organizations that employ them. These actions serve as reminders that physicians are increasingly held accountable for arrangements that may be in violation of multiple federal laws. As such, healthcare organizations that employ and/or contract with physicians must hold physicians accountable for regulatory compliance as part of the compensation arrangement to limit the organization's exposure to risk. The consequences of physician noncompliance can be severe.

Examples of these agencies' recent significant legal actions involving physician conduct are:

- July 2017: $1.3 billion in false billings to Medicare and Medicaid related to joint injections, opioid prescriptions, and drug screenings;[3]
- November 2017: $6.6 million in fraudulent claims to Medicare for nonemergency transports of dialysis patients;[4]
- January 2018: $2 million in restitution and four years in prison for a home health kickback and identity theft scheme;[5]
- February 2018: $63 million false billing for partial hospitalizations involving a community mental health center;[6] and
- March 2018: $30 million for pharmacy marketers who paid physicians to write prescriptions for expensive topical compounded medications.[7]

In addition, executives and members of boards of directors may potentially be held responsible for any organizational noncompliance.[8] The closer alignment of hospitals and physicians under new models of care delivery requires greater board oversight of compensation arrangements. The Department of Justice's focus on individual accountability leaves little doubt that efforts to assert individual accountability extends to officers and executives who "lead or participate" in activities perceived to be illegal conduct.

Goals of a review

In most healthcare organizations, physicians represent the highest paid group of employees. As such, healthcare organizations must develop and implement a robust review process of all physician compensation arrangements to ensure such contracts comply with regulatory and policy requirements. This review process serves to provide oversight of increasing integration of services and financial relationships with physicians, while helping to mitigate aggressive government enforcement efforts, unyielding penalties, and organizational risk.

The objectives of physician arrangements or contracts review are numerous and may include, but are not limited to:

- Gaining an overview and oversight of organization-wide contracting practices;
- Uncovering potentially noncompliant arrangements (or that have become noncompliant over time), bringing them to the attention of the compliance officer, the Legal Services department, and other appropriate internal and external parties;

- Examining compensation to assure consistency with FMV and commercial reasonableness;
- Ensuring that all arrangements have the necessary, accurate supporting documentation;
- Evaluating a system for duplicative services and agreements; and
- Determining whether contract management systems are complete and appropriately maintained.

Multiple types of physician compensation arrangements may be necessary for healthcare organizations, including, but not limited to:

- Employment
- Professional services
- Income guarantee or support
- Loan repayment
- Recruitment
- On-call pay
- Joint ventures
- Administrative positions
- Co-management services
- Facility and equipment leasing

Delineate a robust review process

A solid and robust compensation review process is needed to address the complex risks and challenges in physician arrangements.

The team

For the review process to be efficient and successful, a competent and trained team should be appointed, preferably including those who have experience conducting contract evaluations. A specific team helps maintain continuity during the review process. The roles of counsel, compliance officer, consultants, and other team members should also be clarified as part of project initiation.

The process and approach

Once a team has been appointed, its members must define and refine the process and approach. A critical initial component is to first review and gain an understanding of the current method for undertaking arrangement reviews. As part of this process, the team should be able to determine the individuals responsible for the daily management of physician arrangements. The purpose of the review must be clearly formulated, determining whether it is for internal audit purposes or for reporting requirements.

The contracts

One of the responsibilities of the review team is to locate all of the physician contracts and related supporting documents. For example, determining whether they are housed in a centralized repository, or decentralized among different departments, is critical to an efficient and effective review process.

The review sample

The team needs to determine the sample size, which should include a representative cross-section of contract types depending on the focus of the engagement, such as employment, medical director, personal services agreement, recruitment, facility lease, etc. With the sample selected, the contracts are then compiled for the review. This frequently includes generating a list of contracts from the contract management system by category pertaining to the scope of the review.

The supporting documentation

In order to complete the arrangements review, essential information is required, including:

- The contracts to review;
- Supporting written documentation, including but not limited to, items such as time sheets and needs assessments;
- Payment data from Accounts Payable and the Payroll department, including Form 1099 information;
- Related policies and procedures, for example:
  - Physician compensation philosophy

- ✧ Execution and controls for physician employment and personal services arrangements
- ✧ Management, payment, and auditing of physician compensation arrangements

Key items necessary for review are also further detailed later in the section, "A helpful checklist."

The project plan

A fundamental component to facilitating a successful physician arrangements review includes the development and execution of a formal project plan to help ensure that all parties involved do the following:

- ◆ Participate in regular team meetings and phone calls
- ◆ Establish a communications plan that helps team members efficiently share information
- ◆ Review pertinent findings throughout the process
- ◆ Use an arrangement review checklist that has been approved by legal counsel

The project plan will provide structure for the team members to follow a course of action to complete the review; document findings, questions, and the need for additional information; and report review results regularly to the team leader.

Process deliverables

When reporting the results of physician compensation arrangements reviews, it is important to provide details on the background, scope, approach, and a synopsis of the results. Detailing the discoveries sufficiently is critical in order to proceed with implementable action plans and prioritize each finding by evaluating the risk to an organization. Failure to do so in a meaningful way will stymie the ability of an organization to make the necessary process improvements. Any recommended corrective action should be based on the level of risk to an organization and the risk appetite of governance. Specifically, the review should identify any missing or deficient policies and procedures. Further, if a physician was compensated inappropriately, payment for any associated services must be analyzed to determine if repayments or refunds are required.

Any recommended corrective action should be based on the level of risk to an organization and the risk appetite of governance.

Apply best practices and strong internal controls

Organizations should be proactive and implement strong internal controls to guarantee that physician arrangements are executed properly when the contract is initiated, to potentially mitigate any compliance violations. They must also stay abreast of current regulations, maintain a process for receiving regulatory updates, develop a checklist to assure that proper processes are followed, and address all required elements appropriately. Further, they must justify the arrangements in order to pass outside agency scrutiny.

A basic control for any review of physician arrangements is that the agreement is signed by both parties. Although physicians who are bona fide employees do not require a written arrangement, having one can help document compliance with other required elements. Physicians who are not employed must have a signed written arrangement with the healthcare facility or organization before compensation is paid or services are performed, to avoid possible Stark violations.

Upon initiation, physician arrangements should be monitored regularly as part of the organizational compliance work plan. Written contracts must specify all services and items covered by the arrangements between the parties and must document circumstances that gave rise to an agreement. For example, a physician needs assessment or medical staff development plan can afford health facilities more latitude in offering incentives for physician recruitment and compensation based on the health needs of the community. Such assessment verifies the need for additional physician services or specialties and serves as part of an organization's efforts to comply with federal physician recruiting regulations.

Pursuant to the identified regulatory considerations, contracts must pay FMV compensation for the agreed-upon services. Regular reviews can help identify the need for correction of any excessive compensation arrangements. The total compensation for each physician should be market-based and reasonable in an economic sense. For example, arrangements in which a physician has more than one

contract with the same organization, or "stacked arrangements," can result in duplication of payment for the same services, triggering a "red flag" from both FMV and commercial reasonableness perspectives.

Regulatory oversight agencies require that payment arrangements are set in advance if physicians refer services to an organization with which they are under contract. For example, the compensation formula for independent contractors must always be set in advance and their compensation may not be adjusted retroactively. For personal services agreements, the aggregate compensation, not only the compensation formula, must be set in advance.

In addition, although there is a Stark exception for nonmonetary physician compensation, these benefits must be tracked and reported.[9] In general, the nonmonetary compensation exception may be used to protect items or services such as entertainment, meals, and other noncash equivalent benefits provided to a physician. Hospitals may provide nonmonetary compensation to physicians up to an aggregate amount of $407 for calendar year 2018. Additionally, the dollar limit for "incidental benefits" (e.g., meals, parking, use of internet) is less than $34 per occurrence. Hospitals should inventory such nonmonetary compensation and benefits to confirm they are meeting the law's requirements.

Finally, there should be an approved commercial reasonableness process in place. Documented best practices in support of a transaction make business sense in the absence of a referral stream.

Specifically, a proposed arrangement must demonstrate reasonable necessity to accomplish a rational business purpose. The particular nature of the duties and the corresponding amount of accountability under the proposed arrangement must be clearly defined and reasonable. In addition to other supporting factors, patient demands, the number of hospital patients, or the needs of the community must be sufficient to justify services.

Many healthcare organizations are not traditionally set up to manage the risks and address the uniqueness of physician compensation arrangements compliance. Employing best practices and robust internal controls can position the organization to mitigate significant compliance risks and to achieve assurance over operational effectiveness or regulatory compliance. Effectively designed, centrally managed, and periodically reviewed internal control functions are the single best method for maintaining regulatory compliance with physician compensation arrangements.

A helpful checklist

A physician compensation arrangement review checklist supports healthcare enterprises in taking the first steps toward initiating and managing physician compensation arrangements. The following critical elements can assist healthcare organizations when undertaking reviews:

- Establish physician classification—as an employee, contractor, or other
- Identify the duties the physician will provide, and whether any are duplicative
- Confirm that all parties have signed all agreements, and that they have legal counsel approval
- Ensure that the contract details the methodology for compensation
- Ensure FMV and commercial reasonableness assessments have been completed for any arrangement
- Determine whether the term of the contract is for at least one year, and whether it can be terminated without notice within one year
- Verify that the contract includes an annual performance evaluation and functional metrics that ensure that care, treatment, and services provided are administered safely and effectively
- Determine whether the contract requires the physician to document the delivered services and hours spent performing duties
- Review all supplemental compensation to determine if it is provided within the terms of the agreement
- Determine if physician payment aligns with the contract
- Prioritize physician compensation risks, including

In addition to other supporting factors, patient demands, the number of hospital patients, or the needs of the community must be sufficient to justify services.

stacked agreements and long-standing evergreen contracts
- Review real estate and equipment leasing agreements that involve physicians

Conclusion

As the number of employed and contracted physicians continues to increase, the regulatory and legal compliance of physician compensation arrangements will loom large, drawing further scrutiny from oversight agencies. Hospital and healthcare executives must expand their responsibility for oversight to assure that these arrangements provide fair, market-based compensation that complies with regulatory requirements. Contract development and implementation—as well as maintenance of supporting documentation, and regular, thorough reviews—are the fundamental components of a robust process to mitigate and prevent any potential compensation issues. CT

Endnotes

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8. DOJ Office of the Deputy Attorney General, The Yates Memo, September 9, 2015. https://bit.ly/2nLMPa4
9. 42 C.F.R. § 411.357 (Exceptions to the referral prohibition related to compensation arrangements)

- Increasingly, healthcare organizations' business strategies include employing/contracting with physicians.
- Regulatory/legal considerations demand management's thorough oversight of physician arrangements.
- Physician arrangements are often complex and multifaceted.
- Regulatory/legal violations can invoke steep penalties and reputational damage.
- Technical reviews of physician arrangements/strong internal controls are critical.